DEPARTMENT OF SOCIAL AND HEALTH SERVICES
MEDICAL ASSISTANCE ADMINISTRATION
Olympia, Washington

To: Pharmacies
All Prescribers
Managed Care Plans
Nursing Home Administrators

From: Douglas Porter, Assistant Secretary
Medical Assistance Administration

Memorandum No: 05-76 MAA
Issued: August 1, 2005

For More Information, call:
1-800-562-6188

Subject: **Prescription Drug Program: New Drug Initiative - Minimize Therapeutic Duplication of Second-Generation Antidepressants, Additional Information regarding Antidepressants on the WAPDL, and Changes to EPA**

Effective for claims with dates of service on and after September 1, 2005, unless otherwise noted, MAA will:

- Require prior authorization for pharmacy claims for therapeutic duplication(s) of second-generation antidepressants when the duplication(s) exceed 68 days; and
- Implement the expedited prior authorization (EPA) changes listed in this memo.

New Drug Initiative: Minimize Therapeutic Duplication of Second-Generation Antidepressants

Effective for claims with dates of service on and after September 1, 2005, MAA will allow pharmacy claims for therapeutic duplications of second-generation antidepressants for 68 days only. Any claim(s) for therapeutic duplication(s) that exceed 68 days will require prior authorization (PA). To request PA, fax MAA at 1-360-725-2141 or call 1-800-848-2842 (option 1). Mental health experts participating in MAA's Mental Health Drug Initiatives Stakeholder Workgroup determined which drugs in this class are to be considered duplicative, based on the mechanism of action.

☞ **Note:** The boxes below marked with "PA" indicate the combinations that will require prior authorization after 68 days of concurrent therapy.

	SSRI	NaSSA	NDRI	SARI	SNRI
SSRI*	**PA**				
NaSSA		**PA**			
NDRI			**PA**		
SARI	**PA**	**PA**		**PA**	
SNRI	**PA**				**PA**

Legend:

- **SSRI** - (Selective Serotonin Reuptake Inhibitor such as fluoxetine, citalopram, escitalopram, fluvoxamine, paroxetine, and sertraline)
- **NaSSA** - (Noradrenergic and Specific Serotonergic Antidepressant such as mirtazapine)
- **NDRI** - (Norepinephrine/Dopamine Reuptake Inhibitor such as bupropion)
- **SARI** - (Serotonin Antagonist Reuptake Inhibitor such as nefazodone)
- **SNRI** - (Serotonin Norepinephrine Reuptake Inhibitor such as duloxetine and venlafaxine)

Second-Generation Antidepressants on the Preferred Drug List:

Effective for claims with dates of service on and after July 1, 2005, MAA added second-generation antidepressants to the Washington Preferred Drug List (WAPDL). Antidepressants are the first drug class added to the WAPDL which are specified in Senate Bill 6088 as exempt from Therapeutic Interchange or Preferred Drug List (PDL) requirements when they are a continuation of previously established therapy. To meet this requirement, MAA reconfigured the Point-of-Sale system to recognize when a prescription is a known continuation of therapy.

If a client has previously received the same antidepressant medication within the last 180 days, non-preferred antidepressants will bypass PDL edits without the need for authorization. If a prescription is a continuation of therapy which has not been recognized by our system, please have that information available when calling for prior authorization.

Note: This exemption applies **only** to WAPDL requirements. It does not affect the need for authorization if there has been a duplication of therapy in excess of 68 days.

Expedited Prior Authorization (EPA) Changes

Effective the week of September 5, 2005:

Drug	Code	Criteria
Focalin XR *(dexmethylphenidate HCl)*	061	Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) and all of the following: a) The prescriber is an authorized schedule II prescriber; b) Total daily dose is administered as a single dose; and c) The patient is six years of age or older.

Billing Instructions Replacement Pages

Attached are replacement pages H.9 and H.10 for MAA's *Prescription Drug Program Billing Instructions.*

How can I get MAA's provider issuances?

To obtain MAA's provider numbered memoranda and billing instructions, go to MAA's website at http://maa.dshs.wa.gov (click on the ***Billing Instructions/Numbered Memoranda*** or ***Provider Publications/Fee Schedules*** **link**).

To request a free paper copy from the Department of Printing:

1. **Go to: http://www.prt.wa.gov/** (Orders filled daily.)

   a) Click ***General Store***.

   b) If a **Security Alert** screen is displayed, click **OK.**

      i. Select either ***I'm New*** or ***Been Here***.
      ii. If new, fill out the registration and click ***Register***.
      iii. If returning, type your email and password and then click ***Login***.

   c) At the **Store Lobby** screen, click ***Shop by Agency***. Select ***Department of Social and Health Services*** and then select ***Medical Assistance*****.**

   d) Select ***Billing Instructions, Forms, Healthy Options, Numbered Memo, Publications,*** or ***Issuance Correction***. You will then need to select a year and the select the item by number and title.

2. **Fax/Call:** Dept. of Printing/Attn: Fulfillment at FAX (360) 586-6361/ telephone (360) 586-6360. (Orders may take up to 2 weeks to fill.)

Drug	Code	Criteria
Clozapine **Clozaril®**	018	All of the following must apply: a) There must be an appropriate DSM IV diagnosis present as determined by a qualified mental health professional; and b) Patient is 17 years of age or older; and c) Must be prescribed by a psychiatrist, neurologist, or psychiatric ARNP with prescriptive authority approved for this drug class, or in consultation with one of the above.
Concerta® *(methylphenidate HCl)*	026	Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD) and the prescriber is an authorized schedule II prescriber.
Copegus® *(ribavirin)*	010	Diagnosis of chronic hepatitis C virus infection in patients 18 years of age or older. Patient must be on concomitant alpha interferon or pegylated alpha interferon therapy (not to be used as monotherapy).
Coreg® *(carvedilol)*	057	Diagnosis of congestive heart failure.
Dexedrine® *(D-amphetamine sulfate)*		See criteria for Adderall®.
Dextrostat® *(D-amphetamine sulfate)*		See criteria for Adderall®.
Duragesic® *(fentanyl)*	040	Diagnosis of cancer-related pain.
Enbrel® *(etanercept)*	017	Treatment of rheumatoid arthritis or ankylosing spondylitis when prescribed by a rheumatologist up to 50mg subcutaneously per week for patients who have had an inadequate response to one or more Disease Modifying Anti Rheumatoid Drug (DMARD).
	024	Treatment of psoriatic arthritis when prescribed by a rheumatologist or dermatologist up to 50mg subcutaneously per week for patients who have had an inadequate response to one or more DMARD.
	025	Treatment of plaque psoriasis in patients 18 years of age and older when prescribed by a rheumatologist or dermatologist. Dose not to exceed 50mg subcutaneously twice weekly for the first three months of therapy and not to exceed 50mg weekly thereafter.
Fazaclo® *(clozapine)*	012	All of the following must apply: a) There must be an appropriate DSM IV diagnosis present as determined by a qualified mental health professional; and b) Patient is 18 years of age or older; and c) Must be prescribed by a psychiatrist, neurologist, or psychiatric ARNP with prescriptive authority approved for this drug class, or in consultation with one of the above; and d) Must have tried and failed generic clozapine.
Focalin® *(dexmethylphenidate HCl)*		See criteria for Concerta®.
Focalin XR® *(dexmethylphenidate HCl)*	061	Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) and all of the following: a) The prescriber is an authorized schedule II prescriber; b) Total daily dose is administered as a single dose; and c) The patient is six years of age or older.

Drug	Code	Criteria
Gabitril® *(tiagabine HCl)*	036	Treatment of seizures.
Geodon® *(ziprasidone HCl)*	046	All of the following must apply: a) There must be an appropriate DSM IV diagnosis; and b) Patient is 6 years of age or older.
☞		**Note:** Because Geodon® prolongs the QT interval (< Seroquel® > Risperdal® > Zyprexa®), it is contraindicated in patients with a known history of QT prolongation (including a congenital long QT syndrome), with recent acute myocardial infarction, or with uncompensated heart failure; and in combination with other drugs that prolong the QT interval.
Geodon® IM Injection *(ziprasidone mesylate)*	058	All of the following must apply: a) Diagnosis of acute agitation associated with schizophrenia; b) Patient is 18 years of age or older; and c) Maximum dose of 40mg per day and no more than 3 consecutive days of treatment.
Glycolax Powder® *(polyethylene glycol)*	021	Treatment of occasional constipation. Must have tried and failed a less costly alternative.
Humira Injection® *(adalimumab)*	028	Treatment of rheumatoid arthritis when prescribed by a rheumatologist for patients who have tried and failed one or more DMARD. Dose not to exceed 40mg subcutaneously every two weeks if patient is also receiving methotrexate, or up to 40mg subcutaneously every week if patient is not receiving methotrexate concomitantly.
Infergen® *(interferon alphcon-1)*	134	Treatment of chronic hepatitis C in patients 18 years of age and older with compensated liver disease who have anti-HCV serum antibodies and/or presence of HCV RNA.
Intron A® *(interferon alpha-2b recombinant)*	030	Diagnosis of hairy cell leukemia in patients 18 years of age and older.
	031	Diagnosis of recurring or refractory condyloma acuminate (external genital/perianal area) for intralesional treatment in patients 18 years of age and older.
	032	Diagnosis of AIDS-related Kaposi's sarcoma in patients 18 years of age and older.
	033	Diagnosis of chronic hepatitis B in patients 1 year of age and older.
	107	Diagnosis of malignant melanoma in patients 18 years of age and older.
	109	Treatment of chronic hepatitis C in patients 18 years of age and older.
	135	Diagnosis of follicular non-Hodgkin's lymphoma in patients 18 years of age and older.
Kadian® *(morphine sulfate)*	040	Diagnosis of cancer-related pain.
Keppra™ *(levetiracetam)*		See criteria for Gabitril®.
Kineret Injection® *(anakinra)*	029	Treatment of rheumatoid arthritis when prescribed by a rheumatologist for patients 18 years of age and older who have tried and failed one or more DMARD. Daily dose not to exceed 100mg subcutaneously.
Kytril® *(granisetron HCl)*	127	Prevention of nausea or vomiting associated with moderately to highly emetogenic cancer chemotherapy.
	128	Prevention of nausea or vomiting associated with radiation therapy.